Cornell Research Progam on
Self-Injurious Behavior
in Adolescents and Young Adults

BY JANIS WHITLOCK

What is self-injury?

Who is this for?

Anyone interested in learning more about self-injury

What is included?

Who self-injures
When self-injury starts and how long it lasts
Why people self-injure
Is self-injury a suicidal act?
Factors that contribute to self-injury
Is self-injury addictive?
Is self-injury contagious?
What are the dangers of self-injury?
Detecting self-injury

Self-injury typically refers to a variety of behaviors in which an individual intentionally inflicts harm to his or her body for purposes not socially recognized or sanctioned and without suicidal intent (ISSS, 2007).

Self-injury can include a variety of behaviors but is most commonly associated with:

- intentional cutting, carving, or puncturing of the skin
- scratching
- burning
- ripping or pulling skin or hair
- self-bruising (through punching objects with the intention of hurting oneself or punching oneself directly)

Self-injury is sometimes also called:

- **deliberate self-harm, or self-harm**
- **self-injurious behavior**
- **self-mutilation**
- **cutting**
- **non-suicidal self-injury**

Tattoos and body piercings are not usually considered self-injurious unless done with the intention to harm the body.

Although cutting is one of the most common and well-documented behaviors, self-injury can take many forms. Over 16 other self-injurious behaviors have been documented in a college population and several studies have shown that individuals who self-injure often use multiple methods. Self-injury can be and is performed on any part of the body but most often occurs on the hands, wrists, stomach and thighs. The severity of the act can range from superficial wounds to lasting disfigurement.

Who self-injures?

Gender: It is often assumed that females self-injure more than males, but it is unclear whether or not this is true. Some studies show that females are more likely to self-injure. Others show that males are just as likely to self-injure as females. There is evidence, however, that males and females differ in their reasons for self-injuring and methods used to self-injure. For example, some research suggests that more males may use self-injurious behaviors that lead to self-bruising. They may punch objects or other people with the intention of hurting themselves or use self-battery. In contrast, females are more likely to use better recognized forms of self-injury, such as cutting or scratching.

Race/ethnicity: Research on self-injury and race/ethnicity is also uncertain. Some studies suggest that it may be more common among Caucasians. Other studies show similarly high rates in minority samples. Some even show regional variation in the relationship between self-injury and race/ethnicity.

Sexual orientation: Although little is known about the relationship between self-injury and sexual orientation, research suggests that being a member of a sexual minority group is a risk fac-

tor for self-injury. At least two studies have shown that reporting oneself as bisexual is a particularly strong risk factor for self-injury – especially among females.

Socio-Economic Status: Although parallels between self-injury and eating disorders have led some to speculate that self-injury is most likely to be prevalent among middle and upper income individuals, no existing research supports this assumption. Indeed, the link between self-injury and trauma suggests that self-injury might be prevalent among lower-income populations.

How common is self-injury among adolescents and young adults?

- **Among secondary school and young adult populations, studies find 12% to 24% of young people have self-injured. About a quarter of youth who have self-injured report injuring only once in their lives.**
- **Studies typically find that about 6%-8% of adolescents and young adults report current, chronic self-injury. Most of these young people are likely to use multiple methods and to injure on several areas of their body (though it is common for those who repeatedly self-injure to have a preferred method and body location).**

When does self-injury start and how long does it last?

Self-injury can start early in life. Research suggests that for those with early onset, self-injury may start around the age of 7, although it can begin earlier. Most often, however, self-injury begins in middle adolescence, between the ages of 12 and 15. It can last for weeks, months, or years. For many, self-injury is cyclical rather than linear - meaning that it is used for periods of time, stopped, and then resumed. It would be wrong, however, to assume that self-injury is a fleeting adolescent problem. Data from some studies suggest that well over a quarter of those with self-injury experience report initiating it at 17 years old of age or older – the years many of them are in college or starting into the workforce. Although the majority of college students surveyed report having stopped within five years of starting, it is also clear that for some the behavior can last well into adulthood. It is not yet clear whether or not there are particular self-injury trajectories that vary based on age and context of onset.

Why do people self-injure?

Reasons given for self-injuring are diverse.

Many individuals who self-injure report that feeling overwhelming negative emotion or emotional pressure are the most common triggers. Emotional numbness and sadness are also commonly cited. They report that self-injury provides a way to manage intolerable feelings or a way to experience some sense of feeling.

Self-injury is also used as a means of coping with anxiety or other negative feelings and to relieve stress or pressure.

Self-injury is also used to:

- feel in control over one's body and mind
- express feelings
- distract oneself from other problems
- communicate needs
- create visible and noticeable wounds
- purify oneself
- reenact a trauma in an attempt to resolve it
- protect others from one's emotional pain

Some report doing it simply because it feels good or provides an energy rush (although few report doing so *only* for these reasons). Regardless of the specific reason provided, self-injury may best be understood as a **maladaptive coping mechanism**, but one that works – at least for a while.

Is self-injury a suicidal act?

There are important distinctions between those who cut or injure themselves in order to attempt suicide and those who engage in self-injury in order to cope with overwhelming negative feelings. Most studies find that self-injury is often used as a means of avoiding suicide. Perhaps one of the most paradoxical features of self-injury is that most of those who self-injure report doing so as a means of relieving emotional pain or to feel something in the presence of nothing. Nevertheless, the relationship between self-injury *without* suicidal intent and self-injury *with* suicidal intent is unclear; those who report self-injuring without suicidal intent are also more likely than others to report having considered or attempted suicide. Nevertheless,

Self-injury may be best understood as a maladaptive coping mechanism, but one that works – at least for a while.

since the majority of individuals (approximately 60%) with self-injury history report never considering suicide, non-suicidal self-injury may be best understood as a symptom of distress that, if unsuccessfully resolved, may lead to suicidal behavior.

What factors contribute to self-injury?

In *clinical* populations, self-injury is linked to

- childhood abuse or trauma, especially childhood sexual abuse
- eating disorders
- substance abuse
- post-traumatic stress disorder
- borderline personality disorder
- depression
- anxiety disorders

The lack of empirical research in *non-clinical* populations reinforces the assumption that most or all of self-injury is a product of pre-existing disorders, although more recent research in general populations of adolescent and young adults challenges this assumption.

Is self-injury addictive?

Whether or not self-injury qualifies as a true addiction is unclear but most self-injury researchers agree that self-injury shows some addictive qualities and may serve as a form of self-medication for some individuals. Recognition of the addictive properties of self-injury for some individuals is the basis for the "addiction hypothesis." This theory suggests that self-injury may engage the endogenous opioid system (EOS). The EOS regulates both pain perception and levels of endogenous endorphins. The activation of this system can lead to an increased sense of comfort or integration – at least for a short period of time. Repeated activation of the EOS can cause a tolerance effect: over time, those who self-injure may feel less pain while injuring. The theory also suggests that overstimulation of the EOS can then lead to withdrawal symptoms that spur the desire to self-injure even when there is no obvious trigger.

Is self-injury contagious?

The seemingly rapid spread of self-injury among community populations of youth suggests that there may be a social contagion factor at work. Indeed, self-injury has been shown repeatedly to follow epidemic-like patterns in institutional settings such as hospitals and detention facilities. For many, self-injury is a very private, hidden act. However, anecdotal reports from adults working with youth in school settings report a fad quality to the behavior similar to that which occurs with eating disorders. A recent study of secondary school nurses, counselors and social workers suggests that there may be multiple forms of self-injury in middle and high school settings – some of which include groups of youth injuring as part of a group membership. Causes for the spread of the behavior in non-clinical populations have left many wondering what larger contextual factors might be at work. Some research suggests that the Internet and the increasing prevalence of self-injury in popular media, such as movies, books, and news reports, may play a role in the spread of self-injury.

The seemingly rapid spread of self-injury among community populations of youth suggests that there may be a social contagion factor at work.

What are the dangers of self-injury?

About a quarter of all adolescents and young adults with a history of self-injury report practicing self-injury only once in their lives. Many of these only flirt with the behavior and do not show heightened distress in other ways. However, at least one study has shown that for some youth, even a single episode of self-injury can correlate with a history of abuse and conditions such as suicidality and psychiatric distress. This suggests that there may be a group of adolescents in which a single incident of self-injury is an indicator for other risky behaviors and even a single self-injurious act should be given attention. Studies also show that relatively few individuals who self-injure seek medical assistance when they severely injure themselves. Because of the potential link between self-injury and suicide (see "Is self-injury a suicidal act?" above), self-injury should always be taken seriously - particularly when practiced regularly and using methods that can cause a lot of damage to the body (like cutting).

How does one detect self-injury?

Although relatively common among adolescents, self-injury is often undetected. Arms, fists, and forearms opposite the dominant hand are common areas for injury and often bear the tell-tale signs of self-injury. However, evidence of self-injurious acts can and do appear anywhere on the body.

Other signs include:

- inappropriate dress for season (consistently wearing long sleeves or pants in summer)
- constant use of wrist bands/coverings
- unwillingness to participate in events or activities which require less body coverage (such as swimming or gym class)

- frequent bandages, odd or unexplainable paraphernalia (e.g., razor blades or other implements which could be used to cut or pound)
- heightened signs of depression or anxiety

It is important that questions about the marks be non-threatening and emotionally neutral. Treatment veteran Barent Walsh indicates that he has the most success making patients comfortable and gleaning clinically useful information by demonstrating "respectful curiosity" toward individuals with a history self-injury (for examples of "respectfully curious" questions see our factsheet for parents: http://www.crpsib.com/userfiles/File/Parent%20REV.pdf)

Summary

Non-suicidal self-injury is an increasingly recognized behavior among adolescents and young adults. Knowing what it is, what it is not, how it may be spreading, and how to detect and respectfully intervene is important for parents, educators, medical providers, and youth service providers working with contemporary young people.

FYI

Additional information about self-injury as well as about treatment and recovery can be found at:

http://www.crpsib.com

http://www.selfinjury.com

http://www.siari.co.uk

http://www.thesite.org/healthandwellbeing/mentalhealth/selfharm

Research on which this factsheet is based is drawn from a variety of sources. For additional information about specific studies, see the following review articles and edited academic books:

Heath, N., Toste, J., & Beettam, E. (2006). "I am not well-equipped": High school teachers' perceptions of self-injury. *Canadian Journal of School Psychology, 21,* 73-92.

Jacobson, C. M., & Gould, M. (2007). The epidemiology and phenomenology of non-suicidal self-injurious behavior among adolescents: A critical review of the literature. *Archives of Suicide Research, 11*(2), 129-147.

Klonsky, E. D. (2007). The functions of deliberate self-injury: A review of the evidence. *Clinical Psychology Review, 27*(2), 226-239.

Nixon, M. & Heath, N. (Eds.). (2008). *Self-injury in youth: The essential guide to assessment and intervention* edited by N. Heath and M. K. Nixon. New York: Routledge Press.

Nock, M (Ed.). (2009). *Understanding nonsuicidal self-injury: Origins, assessment, and treatment* (pp. 37-62). Washington, DC: American Psychological Association.

Purington, A., Whitlock, J., & Pochtar, R. (2009). *Non-suicidal self-injury in secondary schools: A descriptive study of prevalence, characteristics, and interventions.* Manuscript submitted for publication.

Whitlock, J., Eckenrode, J., & Silverman, D. (2006). Self-injurious behaviors in a college population. *Pediatrics, 117*(6), 1939-1948.

Whitlock, J. L., Powers, J. L., & Eckenrode, J. (2006). The virtual cutting edge: The internet and adolescent self-injury. *Developmental Psychology, 42*(3), 407-417.

Yates, T. M. (2004). The developmental psychopathology of self-injurious behavior: Compensatory regulation in posttraumatic adaptation. *Clinical Psychological Review, 24,* 35-74.

Suggested Citation

Whitlock, J. (2010). *What is self-injury?* [Fact sheet] Cornell Research Program on Self-Injurious Behavior in Adolescents and Young Adults. Retrieved from http://crpsib.com/factsheet_aboutsi.asp

This research was supported by the Cornell University Agricultural Experiment Station federal formula funds, received from Cooperative State Research, Education and Extension Service, U.S. Department of Agriculture. Any opinions, findings, conclusions, or recommendations expressed in this publication are those of the author(s) and do not necessarily reflect the view of the U.S. Department of Agriculture.